MOM Care
Maternity Care Program
Grievance Form

Beneficiary Name:	Medicaid Number:	Date Filed:
_____	_____	_____
Originating Source of Complaint:	Care Coordinator:	Date Resolved:
_____	_____	_____
Forwarded to MOM Care ◯ Yes ◯ No	Received by:	Date:
Date Forwarded: _____	_____	

Level I Grievance: I, _____, a qualified participant in the MOM Care Program, wish to file a grievance regarding the following:

Statement of Incident or Problem:

_____
_____
_____
_____
_____
_____

_____ _____
Date Patient Signature

Action Taken To Resolve Complaint:

_____
_____
_____

_____ _____
Date Patient Signature

The action detailed above **HAS** _____, **HAS NOT** _____ resolved my complaint to my satisfaction.

_____ _____
Date Patient Signature

I understand that if the MOM Care Administrative Representative was unable to resolved this Grievance, then it is forwarded to the Grievance Committee for Level II review and resolution within (15) working days (receipt of the grievance by the MOM Care to notification of the resolution to the beneficiary.)